PROFESSIONAL PHARMACY GROUP
Specialty Pharmacy

HUMAN IMMUNODEFICIENCY VIRUS SPECIALTY CARE PROGRAM

Phone: 844-223-7510
Fax: 844-673-6161

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Office Contact: _____ Phone: _____
Email: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

ICD-10: _____ Date of Diagnosis: _____ Contraindications: ❑ No ❑ Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
1. CD/4/T-cell		
2. HIV RNA		
3. Viral Load		
4. Liver Biopsy		

Blood Results:

Date Drawn _____ Hgb/Hct: _____ WBC: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 REQUIRED INFORMATION: Front & back copies of pharmacy & medical cards along with charts & labs from last 90 days

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication				Dosage & Strength/Directions	QTY	Refills
NRTIs/NNRTIs						
❑ DESCOVY® 200/25mg ❑ EDURANT® 25mg ❑ EMTRIVA® ❑ EPIVIR®	❑ INTELENCE® ❑ RESCRIPTOR® ❑ RETROVIR® ❑ SUSTIVA®	❑ VIDEX® ❑ VIRAMUNE® ❑ VIRAMUNE XR® ❑ VIREAD®	❑ ZERIT® ❑ ZIAGEN®			
Protease Inhibitors						
❑ APTIVUS® 250mg ❑ CRIXIVAN® ❑ EVOTAZ™ 300/150mg	❑ INVIRASE® ❑ KALETRA® 200/50mg ❑ LEXIVA®	❑ PREZISTA® ❑ REYATAZ® ❑ VIRACEPT®		❑ _____		
❑ NORVIR® 100mg Capsules	❑ NORVIR® 100mg Tablets			❑ Take 2, twice daily (❑ Capsules ❑ Tablets)		
Combinations						
❑ ATRIPLA® 600/200/300mg ❑ BIKTARVY® 50/200/25mg ❑ COMBIVIR® 150/300mg ❑ COMPLERA® 200/25/300mg ❑ DELSTRIGO™ 100/300/300mg ❑ EPZICOM® 600/300mg	❑ GENVOYA® 150/150/200/10mg ❑ JULUCA® 50/25mg ❑ ODEFSEY® 200/25/25mg ❑ PIFELTRO™ 100mg ❑ PREZCOBIX® 800/150mg ❑ STRIBILD® 150/150/200/300mg	❑ SYMTUZA™ 800/150/200/10mg ❑ TRIUMEQ® 600/50/300mg ❑ TRIZIVIR® 300/150/300mg ❑ TRUVADA® 200/300mg		❑ Take 1 tablet, once daily ❑ Take 1 tablet, twice daily ❑ Take 1 tablet, with a meal daily ❑ _____		
Integrase Inhibitor/CCR5 I						
❑ ISENTRESS® 400mg	❑ SELZENTRY®	❑ TIVICAY® 50mg	❑ VITEKTA®	❑ Take 1 tablet, twice daily ❑ _____		
Supportive Medications						
❑ Acyclovir ❑ Bactrim® (TMC/SMZ) ❑ Bactrim® DS(TMP/SMZ)	❑ Dapsone ❑ Diflucan® ❑ Fuzeon®	❑ Tybost® ❑ Valtrex® ❑ Zithromax®	❑ Other			

PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.